Medical Plans Comparison Sheet (Categories D & G)

Category D – Sheriff Deputies/Sergeants (DSA), Lieutenants/Captains (SOMT) Category G – Airport Fire Fighters

	Regence SC Select $20 Group #10008695	**Regence Traditional (No new enrollments)** Group #10008695	**Group Health Options** Group #0617700
Provider Website	www.regence.com	www.regence.com	www.ghc.org
County Website	Click here	Click here	Click here
Customer Service	1-800-962-0301	1-800-962-0301	1- 888-901-4636
24/7 Nurse Line	1-800-267-6729	1-800-267-6729	1-800-297-6877
Plan Booklet	Click here	Click here	Click here
Summary (SBC)	Click here	Click here	Click here
Smoking Cessation	Quit for Life Program	Quit for Life Program	Quit for Life Program
Premium Rates	Click here for premium rates		
Locate a Provider	Click here	Click here	Click here
Description	Preferred Providers (PPO) are Category 1 and are paid at the highest level. Participating Providers (Par) are Category 2 and are paid at the second level of benefits. Category 3 Providers (Non Par) are not contracted and are also in the second level of benefits. Co-pays are waived for Category 3, as there may be balance billing. Not required to choose a Primary Care Provider (PCP) or to seek referrals for most services.	Preferred Providers (PPO) are Category 1 and are paid at the highest level. Participating Providers (Par) are Category 2 and are paid at the second level of benefits. Category 3 Providers (Non Par) are not contracted and therefore not payable for any services except for Emergency Room Physicians ambulance services and medical emergencies, in which case the patient may not have the choice of providers.	To receive benefits, participants must select a clinic and a Primary Care Provider (PCP) from the provider list, except for self-referral benefits provided below. When you need more specialized care, your PCP will refer you to a specialist or extended network provider.
Alternative Health Care	Naturopaths covered same as physician services. Massage therapy incorporated in existing rehabilitation benefits for physical therapy treatment. Massage treatments at a spa are not a covered benefit. Acupuncture covered 12 visits per year. Chemical dependency covered same as chemical dependency benefits. Smoking cessation not covered.		**In-network:** Subject to co-pay; Acupuncture & Naturopathy: $15 co-pay **Out of network:** After Deductible, Member pays $15, Copayment and 20% Co-insurance
Ambulance	Covered at 100%, no dollar limit Includes air ambulance	**Basic:** $100 payable one way, per condition **Major Medical:** covered at 80% after deductible Includes air ambulance	**Inside Network:** 80% Options Network initiated; hospital to hospital transfers covered in full **Outside Network:** 80% after deductible
Coinsurance	When payment is less than 100 percent, You pay the remaining percentage.	When payment is less than 100 percent, You pay the remaining percentage.	**Inside Network:** None **Outside Network:** 20% of allowed amount

Contraceptives	Covered at 100%	Covered at 80%	**Inside Network:** No charge **Outside Network:** Not covered
Deductible	**PPO & Par Provider:** None **Non Par:** $200/person, $600/family	**Basic:** No deductible, except for Physician Office Visits which will be billed as an Office Call **Major Medical:** $50/employee; $100/dependent $200/family maximum	**Inside Network:** None **Outside Network:** $100/person $300/family
Durable Medical Equipment	**Inside Network:** 100% **Outside Network:** 70%	Covered at 80% after deductible	**Inside Network:** Covered in full **Outside Network:** Covered in full after deductible
Durable Medical Supplies	**PPO:** Covered at 80% **Par:** 80% after deductible **Non Par**: 80% after deductible	Covered at 80% after deductible	**Inside Network:** Covered in full **Outside Network:** Covered in full after deductible
Emergency Care	**PPO:** $200 co-pay, Covered at 100% **Par:** $200 co-pay, 100% after deductible **Non Par**: $200 co-pay, 100% after deductible *copay waived if admitted	**Basic:** Paid in full. Accidental injuries within 3 days or emergency illness within 24 hours. **Major Medical:** 80% after deductible	**Inside Network:** $50 co-pay **Outside Network:** $50 co-pay *copay waived if admitted
Eye Exams	Not covered	Not covered	**Inside Network:** $15 co-pay **Outside Network:** Not covered - Refer to Vision Plan
Hearing Exams	**PPO:** Paid in full, no co-pay **Par:** 70% after deductible **Non Par**: 70% after deductible	Not covered	**Inside Network:** $15 co-pay **Outside Network:** $15 co-pay, then 80% after deductible
Home Health Care	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible *No visit limit	Covered at 90% to 130 visits	**Inside Network:** 100% when pre-authorized **Outside Network:** 80% after deductible *No visit limit*
Home Visits	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible	Covered at 90%	**Inside Network:** Covered within Options Network service areas when prescribed as medically necessary by Options Network Provider
Hospice Care	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible	Covered at 90%	**Inside Network:** 100% when provided and coordinated through approved Options Network approved hospice program. **Outside Network:** 80% after deductible
Hospital Services (Room, Board, etc.)	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible	**Basic:** $80/day employee; $70/day dependent **Major Medical:** 80% after deductible	**Inside Network:** Covered in full **Outside Network:** 80% after deductible
Inpatient Hospital	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par:** 70% after deductible	**Basic:** Paid in full **Major Medical:** Paid in full *(Services other than Facility)*	**Inside Network:** Paid in full **Outside Network:** $15 co-pay, then 80% after deductible

Intensive Care	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible	Covered in full	**Inside Network:** Covered in full **Outside Network:** 80% after deductible
Maternity	Covered as any other condition Pregnancies of dependent daughters are covered. *First 21 days of newborn care covered*	**Basic:** 100% **Major Medical:** 100% after deductible for professional services, 80% for facility Pregnancies of dependent daughters are covered. *First 21 days of newborn care covered*	**Inside Network:** Paid in full. Prenatal/postpartum care is covered subject to $15 co-pay per outpatient visit **Outside Network:** 80% after deductible *First 21 days of newborn care covered*
Mental Health Care	**PPO:** $20 co-pay, then covered at 100% **Par:** $20 co-pay, then covered at 100% **Non Par**: 70% after deductible	**Major Medical:** Inpatient - 100%; Outpatient - 100%	**Inside Network:** Inpatient: Covered in full Outpatient: $15 co-pay, deductible applies **Outside Network:** Inpatient: Deductible and coinsurance applies Outpatient: $15 co-pay, deductible and coinsurance applies
Neurodevelopmental	**PPO:** $20 co-pay, then 100% - max 48 visits per year **Par:** $20 co-pay, then 70% after deductible - max 48 visits per year **Non Par**: 70% after deductible- max 48 visits per year *Physician RX required*	80% maximum to 36 visits per year, after deductible for an outpatient occupational therapist.	Covered under Rehabilitation Benefits
Out of Area Benefits	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible Benefits are the same regardless of geographic location. To receive the highest benefit level, members utilize the local Blue Cross/Blue Shield providers.	Benefits are the same regardless of geographic location. To receive the highest benefit level, members utilize the local Blue Cross/Blue Shield providers.	**Coverage worldwide for emergency:** $100 co-pay, 80% after deductible, waived if admitted; The Extended Network Benefits offers you freedom to choose any physician without referral at a greater cost share.
Out of pocket maximums/limit	**PPO & Par:** $2,500/person, $7,500/family **Non Par:**$10,200/person, $30,600/family	**Basic:** No out of pocket **Major Medical:** $375/person	**Inside Network:** $1,000/member; $2,000/family **Outside Network:** $2,100/member, $4,300/family
Outpatient Hospital	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible	**Basic:** Paid in full **Major Medical:** Paid in full *(Services other than Facility)*	**Inside Network:** $15 co-pay **Outside Network:** $15 co-pay, then 80% after deductible
Outpatient Prescription Drugs	$5 co-pay generic/$10 co-pay generic $15 Brand Formulary/$30 Brand Formulary $30 Non-Formulary/$60 Non-Formulary **34 day retail supply / 90 day mail order supply**	**Generic:** 100% **Brand Name:** 80% **34 day retail supply / 90 day mail order supply**	**Inside Network:** $15 co-pay up to 30 day supply **Outside Network:** 80% Generic cost unless brand name is medically necessary. or $20 co-pay (whichever is greater); Must use a Med-Impact pharmacy; mail order not available

Outpatient Surgery	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible	**Basic:** Paid in full	**Inside Network:** $15 co-pay **Outside Network:** $15 co-pay, then 80% after deductible
Physician Office Visits	**PPO:** $20 co-pay, 100% **Par:** $20 co-pay, 70% after deductible **Non Par:** 70% after deductible	**Basic:** 100% Employee & Dependent **Major Medical:** 80% after deductible **Physician Office Visits that are billed as an Office Call are subject to the plan Deductible.*	**Inside Network:** $15 co-pay, covered in full **Outside Network:** $15 co-pay, then 80% after deductible
Physicians	**Category 1 & 2 (PPO and Par).** You will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services. **Category 3 (Non Par).** You may be billed for balances beyond any deductible and/or coinsurance.	**Category 1 & 2 (PPO and Par).** You will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services. **Category 3 (Non Par).** Not covered for services except as above	PCP at Options Network facilities or your choice of any community doctor outside of the network.
Podiatry	**PPO:** $20 co-pay 100% **Par:** $20 co-pay 70% after deductible **Non Par**: 70% after deductible	Covered same as any other condition	**Inside Network:** $15 co-pay; when medically necessary **Outside Network:** 80% after deductible; when medically necessary
Preventative Care	**PPO:** Covered at 100% **Par:** Covered at 100% **Non Par**: 70% after deductible	**PPO:** Covered at 100% **Par:** Covered at 100% **Non Par**: Not covered, except for emergencies and outside the service area.	**Inside Network:** No charge **Outside Network:** Not covered
Radiation Therapy	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible	Covered in full	**Inside Network:** 100% inpatient; Outpatient: $15 co-pay **Outside Network:** 80% after deductible; Outpatient: $15 co-pay, then 80% after deductible
Rehabilitation Therapy	**Inpatient:** No maximum **Outpatient/PPO:** $20 co-pay, then 100% **Par:** $20 co-pay, then 70% **Non Par:** 70% after deductible No yearly maximum for in or outpatient visits *Physician RX required*	**Basic:** 100%, subject to review after 12 visits **Major Medical:** 80%, after deductible Inpatient - up to 32 days per condition; written treatment plan required; Outpatient - up to 55 visits per year (not subject to out of pocket max). *Physician RX required*	**Inpatient:** Covered up to 60 days inside/outside network **Outpatient:** $15 co-pay up to 60 visits/condition **Outside Network:** 80% after deductible
Skilled Nursing	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par:** 70% after deductible *Limited to 90 days per year*	**Basic:** Paid in full when in lieu of hospitalization, 70 days per calendar year	**Inside Network:** Covered with pre-auth by Options Network for acute care hospitalization for up to 60 days **Outside Network:** Not covered

Spinal Manipulations	**PPO:** $20 co-pay, then Covered at 100% **Par:** $20 co-pay, then 70% after deductible **Non Par**: 70% after deductible *10 spinal manipulations per calendar year by a chiropractor or osteopath.	**Basic:** Paid up to $8 per visit; 20 visits per year. X-rays are paid the same as any other condition.	**Inside Network:** $15 co-pay covered up to 10 visits per calendar year. **Outside Network:** $15 co-pay, then 80% up to 10 visits after deductible. *Does not require a referral from PCP*
Surgery Anesthesia	**PPO:** Covered at 100% **Par:** 70% after deductible - **Non Par**: 70% after deductible	**Basic:** Paid in full **Major Medical:** Paid in full	**Inside Network:** Paid in full **Outside Network:** 80% after deductible
Temporomandibular Joint (TMJ) disorders	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible	Covered the same as any other condition	**Inside Network**: Inpatient: Covered in full Outpatient: $15 co-pay **Outside Network**: Inpatient: 80% after deductible Outpatient: $15 co-pay, 80% after deductible
Transplant	**PPO:** 100% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available). **Par:** 70% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available). **Non Par:** 70% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available).	**PPO:** 80% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available). **Par:** 50% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available). **Non Par:** 50% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available).	**Inside Network:** Inpatient: Covered in full Outpatient: $15 co-pay **Outside Network:** Inpatient: 80% after deductible; Outpatient: $15 co-pay, 80% after deductible. *No lifetime maximum. Requires Pre-authorization by plan. No waiting period.
Treatment of Chemical Dependency	**PPO:** Covered at 100% **Par:** 100% **Non Par**: 70% after deductible	Covered in full	**Inside Network:** Inpatient: Covered in full, Outpatient: $15 co-pay, deductible applies. **Outside Network:** Inpatient: Deductible/coinsurance apply Outpatient: $15 co-pay, deductible/coinsurance applies
X-Ray/Lab	**PPO:** Covered at 100% **Par:** 70% after deductible **Non Par**: 70% after deductible **Mammograms covered*	**X-Ray/Lab** **Basic:** Paid in full **Major Medical:** 100% for professional, 80% for facility after deductible **Mammograms covered*	**X-Ray/Lab** **Inside Network:** 100% **Outside Network:** 80% after deductible **Mammograms covered*

REMINDER: This is a general outline of medical benefits and not a guarantee of coverage or service. The information is presented in summary form and should be used for general comparison purposes only. For full details, see plan booklets and/or consult with either Regence or Group Health. Provisions of the plan that are calculated on a calendar year basis are deductibles and Out of Pocket Maximums. Each January 1, those calendar year maximums begin again. Please visit http://snohomishcountywa.gov/983/Medical for more resources.